

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/27/2009
NAME OF PROVIDER OR SUPPLIER BETH ABRAHAM HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 612 ALLERTON AVENUE BRONX, NY 10467	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=L	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to develop and implement policies and procedures to track and monitor laboratory orders and results. This resulted in a 7 day delay in a resident receiving an International Normalized Ratio (INR) blood test while receiving Coumadin (an anticoagulant) therapy. The resident presented with critical lab values, and then expired at the hospital 2 days later.</p> <p>This was evidenced in 1 of 5 sampled residents. (Resident is #1).</p> <p>This deficient practice has the potential to effect all residents that have physician orders for laboratory work.</p> <p>This resulted in Immediate Jeopardy and Substandard Quality of Care to resident health and safety.</p> <p>Complaint # NY00071052</p> <p>The findings are:</p> <p>Resident #1, age 66, was admitted to the facility on 3/9/09. The diagnoses include Toe Amputation</p>	F 309		5/18/09
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	<p>Continued From page 1</p> <p>(2/26/09), Diabetes Mellitus, status post Left Popliteal Bypass and Graft (2/28/09), Peripheral Vascular Disease, and Hypertension. The Minimum Data Set 2.0 dated 3/19/09 noted that the resident had no memory or cognitive impairment.</p> <p>The progress note dated 3/26/09 documented that the resident was transferred to the hospital when redness was noted on the right leg and the resident complained of right foot pain. He was subsequently admitted to the hospital and returned to the facility on 4/6/09 post right 3rd toe amputation and extensive debridement of the right foot.</p> <p>A Comprehensive Care Plan was initiated on 4/11/09 which identified that the resident is at risk for bleeding as he is on anticoagulant therapy. Interventions included monitoring skin for ecchymosis/bruises, monitoring lab values, report to the MD (the physician) accordingly and educating the resident to report signs of bleeding.</p> <p>Review of the hospital laboratory record dated 4/2/09 revealed that on 4/2/09 the resident had an INR blood test result of 2.4 (therapeutic range is - ---2.0 - 3.0). He was on Coumadin (an anticoagulant) 3mg daily.</p> <p>The Medical Admission Note dated 4/7/09 documented that the resident was examined by the physician on 4/7/09 and the resident was on Coumadin 3 mg daily.</p> <p>Review of the physician's orders revealed that a telephone order was received on 4/6/09 for Coumadin 3mg daily and was reviewed and signed on 4/7/09. On 4/7/09, the physician</p>	F 309			

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F 309	<p>Continued From page 2</p> <p>ordered laboratory blood work including a CBC/diff (complete blood count with differential) and an INR.</p> <p>Review of an undated lab requisition form revealed that all of the laboratory orders were transcribed onto the form, including the INR. It is stamped with the resident's addressograph identifying the resident as being in room BR 164. Review of the unit 1BR Lab Book revealed that a lab slip was made out for all of the ordered tests, including the INR. The "Daily Specimen Log" dated 4/7/09 or 4/8/09 did not contain the resident's laboratory testing information.</p> <p>The blood work drawn the morning of 4/8/09 did not include the INR. The laboratory report contained documentation that they were communicated to the facility on 4/8/09. It also included a heading in bold that stated "This Report Contains Critical Values" which consisted of critical lab values for Red Blood Count of 2.81 (normal is 4.20 - 6.0 x10⁶/uL), Hemoglobin of 7.7 (normal is 12.5-16.1 g/dL) and Platelets 630 (normal is 150-450 x10³/uL). There is a heading titled "Coagulation" on the form. The results are documented as "Canceled " with an explanation stating "No Light Blue Top Tube Received." The report incorrectly identified the resident's room number as BR 361B.</p> <p>The Associate Administrator was interviewed on 4/23/09 at 1:15 PM. She stated that during the facility investigation, it was discovered that the laboratory sent a phlebotomist back to the facility later in the day on 4/8/09 to draw the blood for the INR test but it was not done because they could not locate the resident.</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>The phlebotomist was interviewed on 4/23/09 at 1:10 PM. He stated that he was sent to the facility by the laboratory on 4/8/09 to draw the blood for the resident between 3:00 PM and 3:30 PM. He stated that he went to the BR 1 unit and went to room 164 but the resident was not in his room and the nurse did not know where the resident was. He stated that he recommended to the nurse that she write a new requisition slip for the following morning. He did not know the name of the nurse and was unable to describe her.</p> <p>The RN on duty on 1 BR on 4/8/09 from 3PM to 11 PM was interviewed on 4/24/09 at 12:50 PM. She stated that no phlebotomist approached her on 4/8/09 during her shift. She stated that she would have remembered because they rarely see a phlebotomist on the unit during the evening shift hours.</p> <p>The lab results, which revealed that the INR test was not completed and included other critical lab values, were never received on the 1 BR unit according to the above interviews.</p> <p>The physician was interviewed on 4/23/09 at 12:15 PM. She stated that she saw the resident on 4/7/09 and ordered readmission lab blood work, including an INR. She stated that the nurse would have notified her if there were any abnormal laboratory values. She did not receive any report and the resident was stable throughout the week. When she reviewed the medical record on 4/14/09 she noted that there were no results for the laboratory work that she had ordered on 4/7/09 so she wrote a new order for an INR to be done.</p> <p>The Clinical Nurse Manager on duty on the</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>evening of 4/8/09 was interviewed on 4/24/09 at 12:50 PM. She stated that she was covering unit 1BR on 4/8/09, along with 5 additional nursing units. She stated that up until 5 PM the clerks on the units may come up and pick up laboratory reports for their specific units or she herself will bring them down to the units if she is making rounds. There is no way of knowing which reports were actually received and who delivered them to the unit. She further stated that it is her responsibility to review all labs that are faxed in to the office during her shift and if there are any critical values, she will either call the physician or have a nurse call the physician.</p> <p>The Associate Director of Nursing was interviewed on 4/24/09 at 12:15 PM. She stated that she is responsible for units 1BR, 2BR and 3 BR. During a meeting on 4/20/09 she was first informed about the missing laboratory report. After reviewing the medical record herself on 4/20/09, she called the 3 BR unit and asked them to check the office for the report. The unit clerk located the report in the Physician communication book on 3 BR and brought the report down to her.</p> <p>The report for blood work drawn on 4/8/09, which documented incomplete results and the critical lab values, was received at the facility on 4/8/09, was discovered to be on the wrong nursing unit 12 days later. The critical lab values and the fact that the INR was not done were noted on the report. The report was never received by the correct nursing unit or by the Physician.</p> <p>The facility policy titled Lab Specimen Collection and Monitoring with an effective date of 1/5/09 was reviewed. It stated that the unit clerk or nurse will transcribe the order to a lab request slip and</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>the Daily Specimen Log. Both the log and the slip go into the Lab Book under the date the test or specimen is to be collected. If the resident accepts the testing, the phlebotomist will verify the same by signing the Daily Specimen Log. Results are faxed and the unit clerks obtain the paperwork from the Nursing Office during the day tour. The results are delivered to the individual units for review by the unit nurse, who then would check off that the results were received. The policy did not include the tracking of all laboratory orders to ensure that they are completed and results are received and reported to the Physician. The facility policies and procedures do not include the tracking and reporting of laboratory results with critical values.</p> <p>The Director of Clinical Services was interviewed on 4/23/09 at 11:45 AM. She stated that the facility changed from an onsite laboratory to an offsite laboratory effective 1/5/09. The facility staff members were in-serviced on the new policy and procedure which included the use of the Daily Specimen Log form.</p> <p>The agreement between the facility and the laboratory with an effective date of 1/5/09 was reviewed. Under 105(c) it stated "panic results: Such results will be immediately phoned into the facility upon completion of confirmatory specimen testing."</p> <p>The RN that transcribed the physician's orders on 4/7/09 was interviewed on 4/24/09 at 7:05 AM. He stated that he did not transcribe the lab order onto the Daily Specimen Log form because it was an entirely new process and he was too busy on that day. He further stated that he was not aware that the Daily Specimen Log form had been in effect</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>since January 5, 2009, but admitted to having been in-serviced on the laboratory procedures prior to January 2009. He stated that they were still working out the "kinks" with that sheet and it was a new procedure.</p> <p>Review of the physician's order form revealed that the physician wrote an order on 4/14/09 at 1:10 PM for an INR test. Review of the laboratory results report revealed that the blood was collected on 4/15/09 at 6:25 AM and had a reporting date of 4/16/09. It revealed an INR of greater than 10 (normal is 2.0 to 3.0) and an Prothrombin Time (PT) of greater that 50.0 (normal range is 9.9 to 12.9 seconds).</p> <p>The report did not specify what time on 4/16/09 it was reported to the facility, yet during the interview with the physician on 4/23/09, she stated that she and the Nursing Supervisor were notified on 4/16/09 at approximately 9:30 AM.</p> <p>The resident was transferred to the hospital on 4/16/09. Review of the hospital medical record revealed that blood work was collected on 4/16/09 at 12:21 PM with results including Hemoglobin of 4.0 g/dL (normal range 14.0 -17.4 g/dL), Prothrombin Time of >90 seconds (normal rage 9.5-12.0), and an INR of >9.2 ratio (normal range 0.9 -1.2).</p> <p>The Associate Administrator and the Medical Director were interviewed on 4/23/09 at 1:15 PM and stated that there is no written policy and procedure regarding the reporting of critical lab values. There is a verbal agreement with the lab that they will report, by telephone to the Nursing Office, any critical lab results on a daily basis.</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>During the same interview with the Associate Administrator, she stated that the laboratory claimed that the report was faxed to the facility, but there was no evidence that it was received. She also stated that the laboratory is unable to identify what phone numbers the technician called during the morning hours of 4/16/09.</p> <p>The Director at the laboratory company was interviewed on 4/27/09 at 9:30 AM. He stated the technicians have a list of all the nursing unit phone numbers at the facility as well as the nursing office phone number. He further stated that if there are any critical lab values with routine lab tests such as CBC, Chemistry, and INRs, that are collected during the morning, they should be reported to the facility by 2:00 PM.</p> <p>A review of laboratory books for 8 different nursing units was conducted on 4/24/09 between 5:00 AM and 8:00 AM. They revealed discrepancies related to the implementation of the policy the has been in effect since 1/5/09. Examples include:</p> <ul style="list-style-type: none"> - on 1of 8 units it was noted that log sheets were not completed on a consistent basis. An order that was transcribed on 4/23/09 for blood work to be drawn on 4/27/09 was not documented on the Daily Log Specimen form. - on 7of 8 units the Daily Log Specimen forms were incomplete. Specifically, the entries for " results received " were not completed. - on 4 of 8 units it was noted that the "results received" column was being initialed by the laboratory technician upon drawing the blood. -Staff on 2 of the 8 units toured stated that they had a separate binder for lab requests and a separate one for completed labs. Staff on the other 6 units did not identify the use of a Lab 	F 309			

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F 309	Continued From page 8 Result Binder. The facility failed to follow a written order by the Physician requiring that an INR blood test be drawn following readmission from the hospital on 4/8/09. The facility did not identify that the INR was not completed until 4/14/09. This resulted in a second physician's order for an INR on 4/14/09, which was drawn on 4/15/09 at 6:25 AM. Critical lab values were not identified and reported to the Physician until 4/16/09 at 9:30 AM which was 27 hours after it was drawn.	F 309			
F 490 SS=L	415.12 483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The Administrator failed to ensure that the facility operated in a manner in which its policies are developed, implemented, and evaluated for effectiveness. There was no policy in place to ensure that laboratory orders were tracked or that critical lab values were reported to the Physician in a timely manner. This was evidenced in 1 of 5 sampled residents. (Resident is #1). This deficient practice has the potential to effect all residents that have physician orders for laboratory work.	F 490		5/18/09	

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F 490	Continued From page 9 This resulted in Immediate Jeopardy and Substandard Quality of Care to resident health and safety. Complaint # NY00071052 The findings are: The Administrator and Associate Administrator were interviewed on 4/24/09 at 1:15 PM. They stated that the facility did not have a policy for tracking laboratory results. They also stated that there was a verbal agreement with the laboratory that all INR and all stat/panic values are to be called to the facility by 2:00 PM. See F-309-L	F 490			
F 501 SS=L	415.26 483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: The Medical Director did not ensure that the facility developed, reviewed and/or implemented resident care policies that included the tracking of laboratory results and the reporting of critical values in a timely manner.	F 501		5/18/09	

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F 501	Continued From page 10 This was evidenced in 1 of 5 sampled residents. (Resident is #1). This resulted in Immediate Jeopardy and Substandard Quality of Care to resident health and safety. Complaint # NY00071052 The findings are: The Medical Director was interviewed on 4/24/09 at 12:45 PM. She stated that on 1/5/09 the facility changed from an in-house laboratory to an off-site laboratory. She stated that the facility did not have a written policy in place for receiving critical lab values, but that there was a verbal agreement with the laboratory that critical lab results will be reported by 2:00 PM each day to the nursing office. See F- 309-L	F 501			
F 502 SS=L	415.15(a) 483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: The facility failed to ensure that the laboratory services provider reported accurate and timely results to meet the needs of its residents.	F 502		5/18/09	

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F 502	<p>Continued From page 11</p> <p>This was evidenced in 1 of 5 sampled residents. (Resident is #1).</p> <p>This resulted in Immediate Jeopardy and Substandard Quality of Care to resident health and safety.</p> <p>Complaint # NY00071052</p> <p>The findings are:</p> <p>The laboratory services provider failed to inform nursing and medical staff of critical laboratory values in a timely manner on 4/8/09 and again on 4/15/09. The facility did not have policies and procedures in place to ensure communication of critical lab values in a timely manner.</p> <p>Review of Resident #1's undated lab requisition form revealed that all of the laboratory orders written on 4/7/09 were transcribed onto the form, including the INR. It is stamped with the resident's addressograph identifying the resident as being in room BR 164 and does not include the date the blood was to be collected.</p> <p>All the blood work that was ordered on 4/7/09 was drawn on the morning of 4/8/09 with the exception of the INR.</p> <p>The laboratory report dated 4/8/09 was reviewed. The laboratory report was communicated to the facility on 4/8/09 as documented on the report. It also included a heading in bold that stated "This Report Contains Critical Values" which consisted of critical lab values for Red Blood Count of 2.81 (normal is 4.20 - 6.0 x10⁶/uL), Hemoglobin of 7.7 (normal is 12.5-16.1 g/dL) and Platelets 630 (normal is 150-450 x10³/uL). There is a heading</p>	F 502		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/27/2009
NAME OF PROVIDER OR SUPPLIER BETH ABRAHAM HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 612 ALLERTON AVENUE BRONX, NY 10467		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 502	<p>Continued From page 12</p> <p>titled "Coagulation" on the form. The results are documented as "Canceled" with an explanation stating "No Light Blue Top Tube Received." The report incorrectly identified the resident's room number as BR 361B.</p> <p>The Associate Administrator was interviewed on 4/23/09 at 1:15 PM. She stated that during the facility investigation, it was discovered that the laboratory sent a phlebotomist back to the facility later in the day on 4/8/09 to draw the blood for INR test but it was not done because they could not locate the resident.</p> <p>The phlebotomist was interviewed on 4/23/09 at 1:10 PM. He stated that he was sent to the facility by the laboratory on 4/8/09 to draw the blood for the resident between 3:00 PM and 3:30 PM. He stated that he went to the BR 1 unit and went to room 164 but the resident was not in his room. The nurse did not know where the resident was. He then stated that he recommended to the nurse that she write a new requisition slip for the following morning. He did not know the name of the nurse and was unable to describe her.</p> <p>The RN on duty on 1 BR on 4/8/09 from 3PM to 11 PM was interviewed on 4/24/09 at 12:50 PM. She stated that no phlebotomist approached her on 4/8/09 during her shift. She stated that she would have remembered because they rarely see a phlebotomist on the unit during the evening shift hours.</p> <p>The lab results dated 4/8/09, which revealed that the INR test was not completed and included critical lab values, were never received on the 1 BR unit according to interview with staff.</p>	F 502			

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F 502	<p>Continued From page 13</p> <p>The agreement between the facility and the laboratory with an effective date of 1/5/09 was reviewed. Under 105(c) it stated "panic results: Such results will be immediately phoned into the facility upon completion of confirmatory specimen testing."</p> <p>The Director at the laboratory company was interviewed on 4/27/09 at 9:30 AM. He stated the technicians have a list of all the nursing unit phone numbers at the facility as well as the nursing office. They requested the phone company records to verify the technician's statement. He continued to state that if there are any critical lab values with routine lab tests that are collected during the morning, they will be reported by 2:00 PM. Other labs that are run later in the day are reported when done. Any labs that are ordered to be "stat" (immediate) usually take 4 to 5 hours from the initial call to the lab.</p> <p>There is no documentation that critical lab values were received by the facility on 4/8/09.</p> <p>Review of the physician's order form revealed that the physician wrote an order on 4/14/09 at 1:10 PM for an INR test. Review of the laboratory results report revealed that the blood was collected on 4/15/09 at 6:25 AM and had a reporting date of 4/16/09. It revealed an INR of greater than 10 (normal is 2.0 to 3.0) and a Prothrombin Time (PT) of greater than 50.0 (normal range is 9.9 to 12.9 seconds).</p> <p>The report did not specify what time on 4/16/09 it was reported to the facility, yet during the interview with the physician on 4/23/09, she stated that she and the Nursing Supervisor were notified on 4/16/09 at approximately 9:30 AM.</p>	F 502			

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F 502	Continued From page 14 The laboratory's investigation into the delay in notification documented that the blood test was "run" at 11:45 AM on 4/15/09 and the instrument failed to release a result. The tech repeated the sample but failed to release the results. The third shift tech realized that the specimen had not been "resulted" and stated that he faxed over the initial report to the nursing home at 3:13 AM on 4/16/09. He then repeated the test and released those results at 3:31 AM. He stated that he attempted to contact the facility at 3:55 AM, 4:23 AM and again at 5:10 AM on 4/16/09 with the results but no one answered the phone. The Associate Administrator and the Medical Director were interviewed on 4/23/09 at 1:15 PM and stated that the facility did not have a written policy and procedure regarding the reporting of critical lab values. There is a verbal agreement that they will report, via telephone to the Nursing Office, any critical lab results on a daily basis. During the interview with the Associate Administrator, she stated that the laboratory claimed to have faxed the report but there is no evidence to that. She also stated that the laboratory is unable to identify what phone numbers the technician was calling during the morning hours of 4/16/09. The laboratory failed to inform the facility of critical lab value results for a total of 21 hours from the time that the laboratory results were available. The facility did not have policies and procedures in place to ensure timely communication of critical lab values.	F 502			

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F 502	Continued From page 15 415.20	F 502			
F 505 SS=L	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: The facility failed to promptly notify the attending physician of laboratory blood work which was incomplete and additionally, failed to notify the physician of critical lab values in a timely manner. This was evidenced in 1 of 5 sampled residents. (Resident is #1). This resulted in Immediate Jeopardy and Substandard Quality of Care to resident health and safety. Complaint # NY00071052 The findings are: Review of the physician's orders reveals that a telephone order was received by the physician on 4/6/09 for Coumadin 3mg daily and was reviewed and signed on 4/7/09. Additionally, on 4/7/09, the physician ordered laboratory blood work to be drawn. This included a CBC/diff (complete blood count with differential) and an INR. The physician was interviewed on 4/23/09 at 12:15 PM and stated that she was never informed of the results of laboratory blood work which she had ordered on 4/8/09, or did she a laboratory report with results . When she noted this on	F 505		5/18/09	

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F 505	<p>Continued From page 16 4/14/09, she reordered only the INR test.</p> <p>The blood work drawn the morning of 4/8/09 did not include the INR. The laboratory report results were communicated to the facility on 4/8/09 as documented on the report. It also included a heading in bold that stated "This Report Contains Critical Values" which consisted of critical lab values for Red Blood Count of 2.81 (normal is 4.20 - 6.0 x10⁶/uL), Hemoglobin of 7.7 (normal is 12.5-16.1 g/dL) and Platelets 630 (normal is 150-450 x10³/uL). There is a heading titled "Coagulation" on the form. The results are documented as "Canceled" with an explanation stating "No Light Blue Top Tube Received." The report incorrectly identified the resident's room number as BR 361B.</p> <p>Review of the lab requisition forms for 4/7/09 and 4/14/09 revealed that all of the laboratory orders were transcribed onto the form, including the INR. It is stamped with the resident's addressograph identifying the resident as being in room BR 164.</p> <p>The Associate Director of Nursing was interviewed on 4/24/09 at 12:15 PM. She stated that she is responsible for units 1BR, 2BR and 3 BR. During a meeting on 4/20/09 she was first informed about the missing laboratory report for the lab work ordered on 4/7/09. After reviewing the medical record herself on 4/20/09, she called the 3 BR unit and asked them to check the office for the report. The unit clerk located the report in the Physician communication book on 3 BR and brought the report down to her.</p>	F 505			

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F 505	Continued From page 17 The Clinical Nurse Manager on duty on the evening of 4/8/09 was interviewed on 4/24/09 at 12:50 PM. She stated that she was covering unit 1BR on 4/8/09. She stated that up until 5 PM the clerks on the units may come up and pick up laboratory reports for their specific units or she herself will bring them down to the units if she is making rounds. There is no way of knowing which reports were actually received and who delivered them to the unit. She further stated that it is her responsibility to review all labs that are faxed in and if there are any critical values, she will either call the physician or have a nurse call the physician. The incomplete results report for blood work drawn on 4/8/09, which also included critical lab results, was received at the facility on 4/8/09 but it was not until 4/20/09, 12 days later, that it was found to be on the wrong nursing unit. These critical lab values were never reported to the physician. 415.20	F 505			

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NAME OF PROVIDER OR SUPPLIER BETH ABRAHAM HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 612 ALLERTON AVENUE BRONX, NY 10467		
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{F 309} SS=F	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	{F 309}		5/18/09	
{F 490} SS=F	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 490}		5/18/09	
{F 501} SS=F	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by:	{F 501}		5/18/09	
{F 502} SS=F	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The	{F 502}		5/18/09	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 502}	Continued From page 1 facility is responsible for the quality and timeliness of the services.	{F 502}			
{F 505} SS=F	This REQUIREMENT is not met as evidenced by: 483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by:	{F 505}		5/18/09	

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 335201	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 6/4/2009
Name of Facility BETH ABRAHAM HEALTH SERVICES	Street Address, City, State, Zip Code 612 ALLERTON AVENUE BRONX, NY 10467	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0309</u>	Correction Completed <u>05/18/2009</u>	ID Prefix <u>F0490</u>	Correction Completed <u>05/18/2009</u>	ID Prefix <u>F0501</u>	Correction Completed <u>05/18/2009</u>
Reg. # <u>483.25</u>		Reg. # <u>483.75</u>		Reg. # <u>483.75(i)</u>	
LSC _____		LSC _____		LSC _____	
ID Prefix <u>F0502</u>	Correction Completed <u>05/18/2009</u>	ID Prefix <u>F0505</u>	Correction Completed <u>05/18/2009</u>	ID Prefix _____	Correction Completed
Reg. # <u>483.75(j)(1)</u>		Reg. # <u>483.75(i)(2)(ii)</u>		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 4/27/2009	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
	YES NO